Table. Univariate predictors of unplanned readmission

	No unplanned readmission (%) N=1157(77.0)	*Unplanned readmission(%) N=349(23.0)*	P *value*
Mean age [StdDev]	68.4 [11.2]	69.8[11.6]	.02
Diabetes mellitus	614 (52.6)	210 (60.2)	.014
Dialysis dependence	103 (6.6)	54 (15.5)	.006
Congestive heart failure	179 (15.3)	76 (21.8)	.006
Tissue loss indication	575 (49.3)	223 (63.9)	<.0001
SFA inflow	218 (18.7)	88 (25.2)	.01
Mean LOS [StdDev]	10.6 [9.7]	12.2 [8.4]	<.0001
Discharge to nursing facility	570 (48.9)	211 (60.5)	.0001
In-hospital wound infection	34 (2.9)	66 (18.9)	<.0001
Postoperative MI	28 (2.4)	19 (5.4)	.007
In-hospital graft failure	46 (3.9)	36 (10.3)	<.0001

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RR5.

Surgical Treatment of Popliteal Aneurysms Using a Posterior Approach: Thirteen Years' Follow-up

Daniela Mazzaccaro[1], Michele Carmo[1], Giovanni Grava[1], Alberto M. Settembrini[1], Raffaello Dallatana[1], Iacopo Barbetta[1], Piergiorgio Settembrini[2]. [1]Division of Vascular Surgery S.Carlo Borromeo Hospital, Milan, Italy; [2]Università degli Studi di Milano, Milan, Italy

Objectives: Long term results of posterior approach (PA) for the treatment of popliteal artery aneurysms are lacking in the literature.

We compared our results with this access with those from a standard medial approach over a 13-years period.

Methods: Clinical data of all patients treated for a popliteal aneurysm between 2/1998 and 10/2011 were retrospectively reviewed and outcomes analyzed: Kaplan-Meier method with log-rank, chi2 and Wilcoxon test were employed for analysis.

Results: A total of 78 aneurysms were treated in 66 patients (65 men). Mean age was 68 years (range 48-96 years). Thirty-six aneurysms were asymptomatic (46%). Mean sac diameter was 2.9±1 cm. A PA was used in 43 cases (55%) and a medial approach (MA) in 35. All PA consisted in aneurysmectomy with an interposition graft with end to end anastomoses; among MA 25 interposition grafts and 10 bypass were perfomed. A PTFE graft was used mostly (57 cases). The two groups differed for age only (median 65,4 for PA vs 72,9 for MA $P = .01$). Five patients had an early thrombosis and required a Fogarty thrombectomy (2 PA and 3 MA, all PTFE grafts). Mortality rate at 30 days was 0%. One patient suffered a peroneal nerve lesion (permanent) and another one a major wound necrosis with tissue loss (both PA). There were no early amputations. Median follow-up was 58,8 months (range 5 days-1667 months). Nine patients died during follow-up for unrelated causes. The 5-year primary and secondary patency rates were 58, 9%±8, 7% and 96, 4%±3, 5% respectively for PA, and 67, 4%±10, 4% and 81, 3%±8, 9% respectively for MA ($P = .41$ for primary patency rate and 0.28 for secondary patency rate). Limb salvage was 100% and 93, 3%±6, 4% at 5 and 10 years respectively for PA and 91, 5%±5, 6% at both time points for MA ($P = .3$).

Conclusions: PA in our experience was burdened by a few more early complications compared to MA. However in the long term it provided results which compare favourably to MA.

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RR6.

The Use of Reentry Devices Improves the Technical Success, Safety, and Patency of Recanalization of Chronic Total Occlusions of the Iliac Arteries

Sadaf S. Ahanchi, Brian Chen, Samuel Steerman, Richard Redlinger, Jean M. Panneton. Department of Surgery Division of Vascular Surgery, Eastern Virginia Medical School, Norfolk, VA

Objectives: Our aim was to analyze the effect of reentry device use on iliac artery chronic total occlusion (CTO) recanalization outcomes.

Methods: A retrospective review of patients with iliac artery CTO treated with subintimal angioplasty (SIA) from 2006 to 2011 was completed. We then compared the outcomes of two groups: those procedures completed with versus those procedures completed without a reentry device using SPSS software (IBM, Armonk, New York).

Results: Of the 121 iliac artery CTOs that underwent SIA, 32 cases used a reentry device while 89 did not. For the entire cohort, the mean age was 65, male 45%, hypertension 76%, hyperlipidemia 71%, diabetes 36%, and CAD 56%. Indications for the procedure included claudication (60%) and critical limb ischemia (40%). The clinical profile and indications for intervention were not statistically different for the 2 groups. Combining TASC C&D lesions, the reentry device group had a trend toward a higher percentage of more advanced lesions compared to the non reentry device group (82% versus 66% $P = .07$). Yet despite the more advanced lesions, the technical success rate was higher in the reentry device group (100% versus 77% $P = .002$). Combined major complication rate, retrograde aortic dissection, and 30-day mortality rate of the reentry group was also reduced (0% versus 10% $P = .04$). Lastly, the 1, 2 and 3 years primary and secondary patency rates, especially with long term follow up, appear to be improved with the use of reentry devices; primary patency at 1, 2, and 3 years for the reentry device group versus the non reentry device